Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MARC T. TAYLOR, MD

Respondent Name
HARTFORD UNDERWRITERS INSURANCE

MFDR Tracking Number
M4-06-4571-02

Carrier's Austin Representative
Box Number 47

MFDR Date Received
March 13, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Sent certified mail with documentation – letter about no contracts 5/26/05."

Amount in Dispute: $675.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Total reimbursement made at the time of the carrier's response to the MFDR/ DWC 60 was $56.19, which represents payments issued on 6/8/05 for $44.95 for CPT 11000 & 9/11/12 for $111.24."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 25, 2005	Professional Medical Services	$675.00	$45.30

AMENDED FINDINGS AND DECISION

This amended findings and decision supersedes all previous decisions rendered in this medical fee dispute between the above requestor and respondent.

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out the applicable fee guideline for professional medical services.
3. The requestor indicated on the table of disputed services that the disputed date of service is April 25, 2006; however, review of the submitted documentation finds that the services were performed on April 25, 2005. The Division concludes that the date listed on the requestor's DWC FORM-60 is the result of a typographical error. The Division will therefore deem the disputed date of service to be August 25, 2005 for the purpose of this review.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45 – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT. THE CHARGES HAVE BEEN PRICED IN ACCORDANCE TO A CONTRACT OWNED OR ACCESS BY A FIRST HEALTH CO. IF YOU HAVE ANY QUESTIONS, PLEASE VISIT WWW.FIRSTHEALTH.COM.
   - 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE OF ANOTHER SERVICE/PROCEDURE. AN EVALUATION AND MANAGEMENT CODE IS ONLY REIMBURSABLE IF DOCUMENTATION INDICATES THE STARRED PROCEDURE WAS NOT THE MAJOR SERVICE.

Issues

1. Are the disputed services subject to a contracted fee agreement between the parties to this dispute?
2. Did the requestor submit the required documentation to support that additional payment is due?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced payment for disputed services with claim adjustment reason code 45 – "CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT. THE CHARGES HAVE BEEN PRICED IN ACCORDANCE TO A CONTRACT OWNED OR ACCESS BY A FIRST HEALTH CO. IF YOU HAVE ANY QUESTIONS, PLEASE VISIT WWW.FIRSTHEALTH.COM." Review of the submitted information found no documentation to support that the disputed services were subject to a contracted fee arrangement between the parties to this dispute. Nevertheless, on August 30, 2012, the Division requested the respondent to provide a copy of the referenced contract(s) to support the alleged payment reduction, pursuant to 28 Texas Administrative Code §133.307(l), which states that "The commission may request other additional information from either party to review the medical fee issues in dispute. The other additional information shall be received by the division within 14 days of receipt of this request." The respondent did not respond to the Division's request for additional information. The Division finds that the above payment reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Former 28 Texas Administrative Code §133.307(e)(2)(B), effective January 1, 2003, 27 *Texas Register* 12282, requires that the request shall include "a copy of each explanation of benefits (EOB) . . . relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB." Review of the submitted documentation finds that the request does not include copies of explanations of benefits regarding procedure codes 15000, 99214, and 99070. Neither has the requestor submitted convincing evidence of carrier receipt of the provider request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(e)(2)(B). Accordingly, these services will not be reviewed for additional payment. Documentation was submitted to support the request for review of procedure codes 11000 and 99212, therefore these services will be reviewed per applicable Division rules and fee guidelines.
3. This dispute relates to professional medical services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.202(b), which requires that "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided" with any additions or exceptions as set forth in the rule. Additionally, §134.202(c) requires that "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%." Reimbursement for the disputed services is calculated as follows:
    - Procedure code 11000, service date April 25, 2005, performed in San Antonio, Texas, has a Medicare payment rate of $44.95. This amount multiplied by the Division's conversion factor of 125% results in a MAR of $56.23
    - Procedure code 99212, service date April 25, 2005, performed in San Antonio, Texas, has a Medicare payment rate of $36.21. This amount multiplied by the Division's conversion factor of 125% results in a MAR of $45.26
4. The total recommended payment for the services in dispute is $101.49. The respondent submitted documentation to support payment of $56.19 for the services in dispute, leaving an additional amount of $45.30 remaining due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $45.30.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $45.30 plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	September 10, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.